FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040634

Facility Name: AMBOY REHAB. & NURSING CENTER, LTD.

Address: 15 WASSON ROAD (Number) AMBOY (City) 61310 (Zip Code)

County: LEE

Telephone Number: (815) 857-2550 **Fax #** (815) 857-2172

IDPA ID Number: 36-3989257-001

Date of Initial License for Current Owners: 01/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	RICHARD S SGARLATA, C.P.A.
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,502	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,502	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,159	2,467	494	8,120	8
9	SNF/PED					9
10	ICF	13,500	7,428		20,928	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,659	9,895	494	29,048	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.82%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 8 and days of care provided 494

Medicare Intermediary Mutual of Ohmaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, L # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	148,433	8,082	5,280	161,795		161,795		161,795			1
2	Food Purchase		138,443		138,443	(15,372)	123,071	(468)	122,603			2
3	Housekeeping	51,719	14,934		66,653		66,653	(82)	66,571			3
4	Laundry	35,601	19,486		55,087		55,087		55,087			4
5	Heat and Other Utilities			75,993	75,993		75,993	413	76,406			5
6	Maintenance	29,429	20,552	18,384	68,365		68,365	3,744	72,109			6
7	Other (specify):*							345	345			7
8	**TOTAL General Services**	265,182	201,497	99,657	566,336	(15,372)	550,964	3,952	554,916			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	892,265	57,805	1,800	951,870		951,870	(3,762)	948,108			10
10a	Therapy		119	1,742	1,861		1,861		1,861			10a
11	Activities	85,357	6,429	3,468	95,254		95,254	(177)	95,077			11
12	Social Services	25,323		3,794	29,117		29,117		29,117			12
13	Nurse Aide Training			4,172	4,172		4,172	64	4,236			13
14	Program Transportation	2,456		77	2,533		2,533		2,533			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,005,401	64,353	21,053	1,090,807		1,090,807	(3,875)	1,086,932			16
	C. General Administration											
17	Administrative	33,607		26,880	60,487		60,487	78,336	138,823			17
18	Directors Fees											18
19	Professional Services			114,129	114,129		114,129	(78,709)	35,420			19
20	Dues, Fees, Subscriptions & Promotions			34,722	34,722		34,722	(28,131)	6,591			20
21	Clerical & General Office Expenses	61,585	4,489	30,393	96,467		96,467	23,984	120,451			21
22	Employee Benefits & Payroll Taxes			237,659	237,659	15,372	253,031	(4,022)	249,009			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,567	1,567		1,567	334	1,901			24
25	Other Admin. Staff Transportation			5,072	5,072		5,072	15	5,087			25
26	Insurance-Prop.Liab.Malpractice			79,919	79,919		79,919	391	80,310			26
27	Other (specify):*							10,510	10,510			27
28	**TOTAL General Administration**	95,192	4,489	530,341	630,022	15,372	645,394	2,708	648,102			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,365,775	270,339	651,051	2,287,165		2,287,165	2,785	2,289,950			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

AMBOY REHAB. & NURSING CENTER, LTD.
0040634
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	15,372	
2	FOOD		15,372

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. #0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			26,698	26,698		26,698	(26)	26,672			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			59,538	59,538		59,538	1,247	60,785			32
33	Real Estate Taxes			29,586	29,586		29,586	971	30,557			33
34	Rent-Facility & Grounds			395,904	395,904		395,904	(200)	395,704			34
35	Rent-Equipment & Vehicles			12,417	12,417		12,417	4,039	16,456			35
36	Other (specify):*											36
37	**TOTAL Ownership**			524,143	524,143		524,143	6,031	530,174			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,541	28,620	37,161		37,161	(37)	37,124			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,254	53,254		53,254		53,254			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		8,541	81,874	90,415		90,415	(37)	90,378			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,365,775	278,880	1,257,068	2,901,723		2,901,723	8,779	2,910,502			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,752)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(468)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(26,891)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(524)	20		28
29	Other-Attach Schedule	(11,582)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (41,217)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	49,996		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 49,996		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 8,779		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

AMBOY REHAB. & NURSING CENTER, LTD.

ID# 0040634

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	non Allowable Legal Fees	(122)	19	2
3	Nursing Supplies	(431)	10	3
4	Collection Fees	(204)	19	4
5	Housekeeping	(82)	3	5
6	Activities	(177)	11	6
7	Dues, Fees, and Subs	(1,133)	20	7
8				8
9	Employee Benefits	(4,022)	22	9
10	Maintenance	(26)	6	10
11	Discounts Earned	(1,766)	10	11
12	Franchise Tax	(50)	21	12
13	Penalties	(2,990)	21	13
14	Capitalized R&M	(579)	6	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(11,582)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS	
	A. General Services												(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(468)											(468)	2
3	Housekeeping	(82)											(82)	3
4	Laundry													4
5	Heat and Other Utilities			413									413	5
6	Maintenance	(605)		2,108	2,241								3,744	6
7	Other (specify):*			59		286							345	7
8	**TOTAL General Services**	(1,155)		2,580	2,241	286							3,952	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,197)					(1,565)						(3,762)	10
10a	Therapy													10a
11	Activities	(177)											(177)	11
12	Social Services													12
13	Nurse Aide Training			64									64	13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(2,374)		64			(1,565)						(3,875)	16
	C. General Administration													
17	Administrative			(26,880)	105,216								78,336	17
18	Directors Fees													18
19	Professional Services	(326)		(78,383)									(78,709)	19
20	Fees, Subscriptions & Promotions	(28,548)		417									(28,131)	20
21	Clerical & General Office Expenses	(3,040)		24,926	2,098								23,984	21
22	Employee Benefits & Payroll Taxes	(4,022)											(4,022)	22
23	Inservice Training & Education													23
24	Travel and Seminar			334									334	24
25	Other Admin. Staff Transportation			15									15	25
26	Insurance-Prop.Liab.Malpractice			391									391	26
27	Other (specify):*			3,304		7,206							10,510	27
28	**TOTAL General Administration**	(35,936)		(75,876)	107,314	7,206							2,708	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,465)		(73,232)	109,555	7,492	(1,565)						2,785	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(1,752)		1,726									(26)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			1,247									1,247	32
33	Real Estate Taxes			971									971	33
34	Rent-Facility & Grounds		(200)										(200)	34
35	Rent-Equipment & Vehicles			4,039									4,039	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(1,752)	(200)	7,983									6,031	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(37)						(37)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(37)						(37)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(41,217)	(200)	(65,249)	109,555	7,492	(1,602)						8,779	45

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				AMBOY, LLC		BUILDING CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	RENT	$ 395,904	AMBOY, LLC		$ 395,704	$ (200)	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 395,904			$ 395,704	$ * (200)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 413	$ 413	15
16	V	6	REPAIRS & MAINT.				2,108	2,108	16
17	V	7	EMP.BEN. - GEN. SERVICES				59	59	17
18	V	13	NURSES AIDE TRAINING				64	64	18
19	V	19	PROFESSIONAL FEES				996	996	19
20	V	20	DUES AND SUBSCRIPTIONS				417	417	20
21	V	21	CLERICAL & GENERAL				24,926	24,926	21
22	V	24	SEMINARS AND TRAVEL				334	334	22
23	V	25	ADMIN. STAFF TRANS.				15	15	23
24	V	26	INSURANCE				391	391	24
25	V	27	EMP.BEN. - GEN. ADMIN.				3,304	3,304	25
26	V	30	DEPRECIATION				1,726	1,726	26
27	V	32	INTEREST				1,247	1,247	27
28	V	33	REAL ESTATE TAXES				971	971	28
29	V	35	EQUIPMENT RENTAL				4,039	4,039	29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0							35
36	V	17	Management Fees	26,880				(26,880)	36
37	V	19	Bookkeeping/Accounting	79,379				(79,379)	37
38	V								38
39	Total			$ 106,259			$ 41,010	$ * (65,249)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 2,241	$ 2,241	15
16	V	10	NURSING CMP - SUE G.				0		16
17	V	17	ADMIN. CMP. - M. MAUER				18,087	18,087	17
18	V	17	ADMIN. CMP. - M. AARON				23,200	23,200	18
19	V	17	ADMIN. CMP. - F. AARON				9,336	9,336	19
20	V	17	ADMIN. CMP. - A. STERN				14,580	14,580	20
21	V	17	ADMIN. CMP. - S. GOLDSTEIN				0		21
22	V	17	ADMIN. CMP. - S. KOPLIN				4,260	4,260	22
23	V	17	ADMIN. CMP. - D. MAGAFAS				4,781	4,781	23
24	V	17	ADMIN. CMP. - E. CASSON				0		24
25	V	17	ADMIN. CMP. - S. BOGEN				16,572	16,572	25
26	V	17	ADMIN. CMP. - S. LEVY				5,264	5,264	26
27	V	17	ADMIN. CMP. - A. STEINER				1,725	1,725	27
28	V	17	ADMIN. CMP. - NON-OWNER				7,411	7,411	28
29	V	21	CLERICAL CMP. - S. AARON				2,098	2,098	29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 109,555	$ * 109,555	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 286	$ 286	15
16	V	15	EMP. BEN.- SUE G.				0		16
17	V	27	EMP. BEN.- M. MAUER				505	505	17
18	V	27	EMP. BEN.- M. AARON				588	588	18
19	V	27	EMP. BEN.- F. AARON				1,152	1,152	19
20	V	27	EMP. BEN.- S. GOLDSTEIN				0		20
21	V	27	EMP. BEN.- S. KOPLIN				907	907	21
22	V	27	EMP. BEN.- D. MAGAFAS				787	787	22
23	V	27	EMP. BEN.- E. CASSON				0		23
24	V	27	EMP. BEN.- S. BOGEN				976	976	24
25	V	27	EMP. BEN.- S. LEVY				721	721	25
26	V	27	EMP. BEN.- A. STEINER				286	286	26
27	V	27	EMP. BEN.- NON-OWNER				997	997	27
28	V	27	EMP. BEN. - S. AARON				287	287	28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 7,492	$ * 7,492	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	DUES, FEES & SUBSCRIPTIONS	$ 0	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	$ 0	$	15
16	V	10	MEDICAL SUPPLIES	5,947	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	4,382	(1,565)	16
17	V	39	ANCILLARY EXPENSE	141	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	104	(37)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,088			$ 4,486	$ * (1,602)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING & MEDICAL SUPPLY	$ 6,280	PHARMCOR, L.L.C.	100.00%	$ 6,280	$	15
16	V	22	EMPLOYEE BENEFITS	1,667	PHARMCOR, L.L.C.	100.00%	1,667		16
17	V	39	ANICILLARY EXPENSE	8,051	PHARMCOR, L.L.C.	100.00%	8,051		17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,998			$ 15,998	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Maury Aaron	Owner	Administrative	20.30	See Attached	1.9	3.80	Alloc Dynamic	$ 23,200	17-7	1
2	Marshall Mauer	Owner	Administrative	18.18	See Attached	1.7	3.40	Alloc Dynamic	18,087	17-7	2
3	Abe Stern	Owner	Administrative		See Attached	0.33	0.66	Alloc Dynamic	14,580	17-7	3
4	Sharon Aaron	Relative	Clerical		See Attached	1.66	4.15	Alloc Dynamic	2,098	21-7	4
5	Sheila Bogen	Owner	Administrative	16.16	See Attached	6.25	13.89	Alloc Dynamic	16,572	17-7	5
6	Fred Aaron	Owner	Administrative	9.29	See Attached	2.92	5.84	Alloc Dynamic	9,336	17-7	6
7	Sue Koplin	Owner	Administrative	0.53	See Attached	2.83	6.29	Alloc Dynamic	4,260	17-7	7
8	Diania Magafas	Owner	Administrative	0.53	See Attached	2.62	5.82	Alloc Dynamic	4,781	17-7	8
9	Dennis Nehmer	Owner	Maintenance	0.53	See Attached	1.66	4.15	Alloc Dynamic	2,241	6-7	9
10											10
11											11
12											12
13								TOTAL	$ 95,155		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	707,726	15	$ 10,055	$ 16,071	29,048	$ 413	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	707,726	15	51,362		29,048	2,108	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	707,726	15	1,448		29,048	59	3
4	13	NURSES AIDE TRAINING	PATIENT DAYS	707,726	15	1,550		29,048	64	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	707,726	15	24,272		29,048	996	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	707,726	15	10,163		29,048	417	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	707,726	15	607,305	465,093	29,048	24,926	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	707,726	15	8,134		29,048	334	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	707,726	15	372		29,048	15	9
10	26	INSURANCE	PATIENT DAYS	707,726	15	9,517		29,048	391	10
11	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	707,726	15	80,498		29,048	3,304	11
12	30	DEPRECIATION	PATIENT DAYS	707,726	15	42,057		29,048	1,726	12
13	32	INTEREST	PATIENT DAYS	707,726	15	30,386		29,048	1,247	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	707,726	15	23,654		29,048	971	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	707,726	15	98,401		29,048	4,039	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 999,174	$ 481,163		$ 41,010	25

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	14	54,000	54,000	2	2,241	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	32,209	32,209			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	14	435,842	435,842	2	18,087	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	45	14	558,156	558,156	2	23,200	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	50	7	160,040	160,040	3	9,336	5
6	17	ADMIN. CMP. - A. STERN	WGHTD. AVG. HOURS	8	14	351,664		0	14,580	6
7	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	50	3	179,079	179,079			7
8	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	45	10	67,732	67,732	3	4,260	8
9	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	10	82,127	82,127	3	4,781	9
10	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	45	2	47,882	47,882			10
11	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	3	119,320	119,320	6	16,572	11
12	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	55	14	126,974	126,974	2	5,264	12
13	17	ADMIN. CMP. - A. STEINER	WGHTD. AVG. HOURS	45	14	41,511	41,511	2	1,725	13
14	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	14	178,292	178,292	2	7,411	14
15	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	14	50,548	50,548	2	2,098	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,485,376	$ 2,133,711		$ 109,555	25

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40		6,887		2	286	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40		2,883				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40		12,175		2	505	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	45		14,155		2	588	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	50		19,744		3	1,152	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	50		18,514				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	45		14,423		3	907	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45		13,516		3	787	8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	45		10,284				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45		7,029		6	976	10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	55		17,400		2	721	11
12	27	EMP. BEN.- A. STEINER	WGHTD. AVG. HOURS	45		6,891		2	286	12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45		23,984		2	997	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40		6,917		2	287	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,802	$		$ 7,492	25

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	20	DUES, FEES & SUBSCRIPTION	DIRECT ALLOCATION							1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						4,382	2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						104	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 4,486	25

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PHARMCOR, L.L.C.
Street Address: 3116 S. OAK PARK
City / State / Zip Code: BERWYN, IL 60402
Phone Number: (708)795-7701
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION						6,280	1
2	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						1,667	2
3	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						8,051	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 15,998	25

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, I # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Intercompany	X									23,799	6
7	Manufactures Bank		X	Line of Credit				400,000			35,739	7
8	Devon Bank		X	Working Capital-	$1,585.00		75,000	30,461	09/01/02	0.0975		8
9	TOTAL Facility Related				$1,585.00		$ 75,000	$ 430,461			$ 59,538	9
	B. Non-Facility Related*											
10	Supplemental Schedule										1,247	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,247	14
15	TOTALS (line 9+line14)						$ 75,000	$ 430,461			$ 60,785	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTI # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Dynamic Allocation	X					$	$			$ 1,247	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 1,247	21

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	29,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	29,557	2
3. Under or (over) accrual (line 2 minus line 1).	$	557	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	30,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	30,557	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	27,237	8
	1996	28,653	9
	1997	28,686	10
	1998	28,179	11
	1999	28,586	12

Real Estate Tax Accrual - 28586 * 1.02 Rounded = 30000

Allocation From Dynamic= $971

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,451 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 5 years

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	134,723	3,429	20	6,738	3,309	37,197	9
10	COMPRESSOR			1996	1,000	26	20	100	74	458	10
11	ROOF WORK			1996	600	15	20	30	15	130	11
12	INWALL HEATING UNIT			1996	1,318	34	20	66	32	286	12
13	INWALL HEATING UNIT			1996	1,486	38	20	74	36	327	13
14											14
15	HEATING UNIT			1997	725	19	20	36	17	141	15
16	ALARM SYSTEM			1997	2,126	55	20	106	51	353	16
17	A/C WORK ON ROOF			1997	1,492	38	20	75	37	256	17
18	SEWER CONSTRUCT			1997	2,650	204	20	133	(71)	443	18
19	CARPET INSTALLATTION			1997	992	25	20	50	25	163	19
20	HEATING UNITS			1998	2,631	67	20	132	65	286	20
21	SIDEWALK			1998	1,522	130	20	76	(54)	203	21
22	DOOR			1998	749	19	20	37	18	105	22
23	ROOFTOP A/C			1999	9,274	238	20	464	226	928	23
24											24
25	PAGE 12-1 REP TOTALS				18,207	467		520	53	3,815	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	PAGE 12A TOTALS				48,833	1,210		2,314	1,104	3,583	35
36	TOTAL (lines 4 thru 35)				$ 228,328	$ 6,014		$ 10,951	$ 4,937	$ 48,674	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOM HEATERS			1999	1,678	43	20	84	41	168	9
10	WATER HEATER			1999	4,273	110	20	214	104	357	10
11	CARPETING			1999	6,937	178	20	347	169	549	11
12	RADIAL SIDEWALK			1999	3,020	77	20	151	74	227	12
13	VALANCES/SHEERS			1999	605	16	20	30	14	45	13
14	CORNICE/SHEER			1999	331	8	20	17	9	26	14
15	CARPET FREIGHT			1999	168	4	20	8	4	11	15
16											16
17	FENCE			1999	6,000	154	20	300	146	425	17
18	CENTRAL HEATING			1999	767	20	20	20		21	18
19	CENTRAL HEATING			1999	2,234	57	20	57		59	19
20	KITCHEN FIRE SYSTEM			1999	980	25	20	49	24	94	20
21	REMODELING-PT Room, Office, Classroom			1999	19,320	495	20	966	471	1,530	21
22	BLOWER FOR A/C			2000	1,941	23	20	49	26	49	22
23	PLUMBING			2000	579		20	22	22	22	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 48,833	$ 1,210		$ 2,314	$ 1,104	$ 3,583	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993	Dynamic	$ 18,207	$ 467	35	$ 520	$ 53	$ 3,815	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 18,207	$ 467		$ 520	$ 53	$ 3,815	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 120,835	$ 18,261	$ 14,370	$ (3,891)		$ 51,143	37
38	Current Year Purchases	17,218	3,383	1,178	(2,205)		1,178	38
39	Fully Depreciated Assets	11,977	576		(576)		11,977	39
40								40
41	TOTALS	$ 150,030	$ 22,220	$ 15,548	$ (6,672)		$ 64,298	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY BUSINESS	VEHICLE	1995	$ 1,114	$ 64	$ 64	$		$ 1,114	42
43	Alloc From Dynamic			653	126	109	(17)		109	43
44										44
45										45
46	TOTALS			$ 1,767	$ 190	$ 173	$ (17)		$ 1,223	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	380,125	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	28,424	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	26,672	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	(1,752)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	114,195	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

AMBOY REHAB. & NURSING CENTER, LTD.
0040634
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Facility	110,854	17,266	13,392	(3,874)	46,408
Dynamic	9,981	995	978	(17)	4,735
TOTALS	120,835	18,261	14,370	(3,891)	51,143
LINE 29: CURRENT YEAR					
Facility	16,526	3,245	1,143	(2,102)	1,143
Dynamic	692	138	35	(103)	35
TOTALS	17,218	3,383	1,178	(2,205)	1,178
LINE 30: FULLY DEPRECIATED					
Facility	11,977	576		(576)	11,977
Dynamic					
TOTALS	11,977	576		(576)	11,977
TOTALS (Should Tie to Totals on Page 13)					
Facility	139,357	21,087	14,535	(6,552)	59,528
Dynamic	10,673	1,133	1,013	(120)	4,770
TOTALS	150,030	22,220	15,548	(6,672)	64,298

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Amboy, LLC pays unrelated party
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1969	97	01/01/95	$ 395,704			3
4	Additions							4
5								5
6								6
7	TOTAL		97		$ 395,704 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 01/01/95
    Ending 12/31/14

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 424,860
13.	/2002	$ 442,562
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 8,956 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Usage	98 Chevrolet Express	$ 625.00	$ 7,500	17
18					18
19					19
20					20
21	TOTAL		$ 625.00	$ 7,500	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		516		516
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		3,206		3,206
8	Nurse Aide Competency Tests		514		514
9	TOTALS	$	$ 4,236	$	$ 4,236
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,236			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$	10,006	$		$ 10,006	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				17,921			17,921	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					8,301		8,301	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2, 39-3					693	240		933	13
14	TOTAL			$		$	28,620	$ 8,541		$ 37,161	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	240
2		
3		
4		
5		
6		
7		
8		
9		
10		
		240

	Outside Therapies (Column 5 - Other)	Amount
1	Lab	693
2		
3		
4		
5		
6		
7		
8		
9		
10		
		693

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 52,165	$ 52,217	1
2	Cash-Patient Deposits	19,901	19,901	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	197,586	197,586	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,800	30,800	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(388,393)	(388,393)	8
9	Other(specify): See supplemental schedule	77,149	77,149	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (10,792)	$ (10,740)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	206,597	206,597	15
16	Equipment, at Historical Cost	143,416	143,416	16
17	Accumulated Depreciation (book methods)	(131,413)	(131,413)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	9,400	9,400	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(9,400)	(9,400)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	91,000	100,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 309,600	$ 318,600	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 298,808	$ 307,860	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 163,628	$ 163,628	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,901	19,901	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	125,927	125,927	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,681	1,681	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,000	30,000	32
33	Accrued Interest Payable	1,945	1,945	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,328	6,328	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 349,410	$ 349,410	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	430,461	430,461	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 430,461	$ 430,461	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 779,871	$ 779,871	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (481,063)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 298,808	$ #REF!	48

***(See instructions.)**

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. **#** 0040634 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	15,327	15,327
Employee Loans	122	122
Due From Shareholders	61,700	61,700
	77,149	77,149

OTHER CURRENT LIABILITIES:	Amount	Amount

OTHER NON CURRENT ASSETS:		
Option Deposit		100,000
Security Deposit - Related Party	91,000	91,000
	91,000	191,000

OTHER NON CURRENT LIABILITIES:	Amount	Amount

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (258,133)	1
2	Restatements (describe):		2
3	**Schedule attached**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (258,133)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(284,630)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **ADDITIONAL PAID IN CAPITAL**	61,700	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (222,930)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (481,063)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	AMBOY REHAB. & NURSING CENT	# 0040634	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(258,133)
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		(258,133)
Equity(Deficit) from Page 17 Col 1		(481,063)
Related Party		
Equity(Deficit)	9052	
Income	0	
		9,052
Combined Equity - End of Year		(472,011)

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,578,603	1
2	Discounts and Allowances for all Levels	(124,210)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,454,393	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	119,550	6
7	Oxygen	8,469	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 128,019	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	6,681	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	12,452	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,306	19
20	Radiology and X-Ray		20
21	Other Medical Services	10,405	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 32,844	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,837	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,837	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,617,093	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	566,336	31
32	Health Care	1,090,807	32
33	General Administration	630,022	33
	B. Capital Expense		
34	Ownership	524,143	34
	C. Ancillary Expense		
35	Special Cost Centers	37,161	35
36	Provider Participation Fee	53,254	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,901,723	40
41	**Income before Income Taxes (line 30 minus line 40)****	(284,630)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (284,630)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number AMBOY REHAB. & NURSING CE # 0040634 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	71
2	Discounts Earned (Adjusted out on P.5)	1,766
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	1,837

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,840	2,072	$ 39,675	$ 19.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,558	7,264	132,223	18.20	3
4	Licensed Practical Nurses	10,376	11,414	180,881	15.85	4
5	Nurse Aides & Orderlies	55,858	57,838	532,578	9.21	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,952	2,136	22,764	10.66	9
10	Activity Assistants	8,280	8,664	62,593	7.22	10
11	Social Service Workers	1,832	2,124	25,323	11.92	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,216	23,635	10.67	13
14	Head Cook	3,888	4,542	37,664	8.29	14
15	Cook Helpers/Assistants	12,363	13,132	87,134	6.64	15
16	Dishwashers					16
17	Maintenance Workers	2,989	3,429	29,429	8.58	17
18	Housekeepers	7,463	7,999	51,719	6.47	18
19	Laundry	5,579	5,898	35,601	6.04	19
20	Administrator	2,048	2,264	33,607	14.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,854	5,675	61,585	10.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	848	920	6,908	7.51	31
32	Other Health Care(specify)					32
33	Other(specify)	360	420	2,456	5.85	33
34	TOTAL (lines 1 - 33)	128,992	138,007	$ 1,365,775 *	$ 9.90	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	149	$ 5,280	1-3	35
36	Medical Director	Monthly	6,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-3	39
40	Physical Therapy Consultant	46	1,593	10a-3	40
41	Occupational Therapy Consultant	4	149	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	70	3,468	11-3	44
45	Social Service Consultant	70	3,794	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	435	$ 22,084		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Van Driver	360	420	$ 2,456	$ 5.85
	360	420	$ 2,456	$ 5.85

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pat Butler	Administrator	0	$ 33,607
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 33,607

B. Administrative - Other

Description	Amount
Dynamic Management Fees	$ 26,880
TOTAL (agree to Schedule V, line 17, col. 3)	$ 26,880
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
	Data Processing	$ 2,012
Dynamic	Accounting	3,864
Frost, Ruttenberg & Rothblatt	Accounting	17,000
Sachnoff & Weaver, LTD	Legal	11,724
Dynamic	Legal	419
Econocare	Purchase Consulting	1,746
Personnel Planners	Unemployment Consulting	1,495
Genisis Computer	Computer Consulting	150
Account Collection Fees-Adjusted out on page 5		204
Dynamic	Bookkeeping	75,515
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 114,129

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,356
Unemployment Compensation Insurance	16,249
FICA Taxes	104,258
Employee Health Insurance	73,902
Employee Meals	15,372
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - other	6,872
TOTAL (agree to Schedule V, line 22, col.8)	$ 249,009

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	5,050
Health Care Worker Background Check	
(Indicate # of checks performed 30)	209
License and fees	103
Dues and Subscriptions	1,136
Advertising and Promotions	26,367
Alloc Dynamic	417
Yellow Page Advertising	524
Less: Public Relations Expense	( )
Non-allowable advertising	(26,891)
Yellow page advertising	(524)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,591

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,567
Alloc Dynamic	334
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,901

**See instructions.

Facility Name & ID Number AMBOY REHAB. & NURSING CENTER, LTD. # 0040634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,097** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **53,253**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **NA**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **15,372** Has any meal income been offset against related costs? **NA** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%14**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **YES** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw